Aetna Better Health® of Florida

MMA and LTSS New Provider Orientation

Florida Provider Relations

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November 2, 2021

Learning objectives

As part of your Aetna Better Health of Florida's new provider orientation, we will:

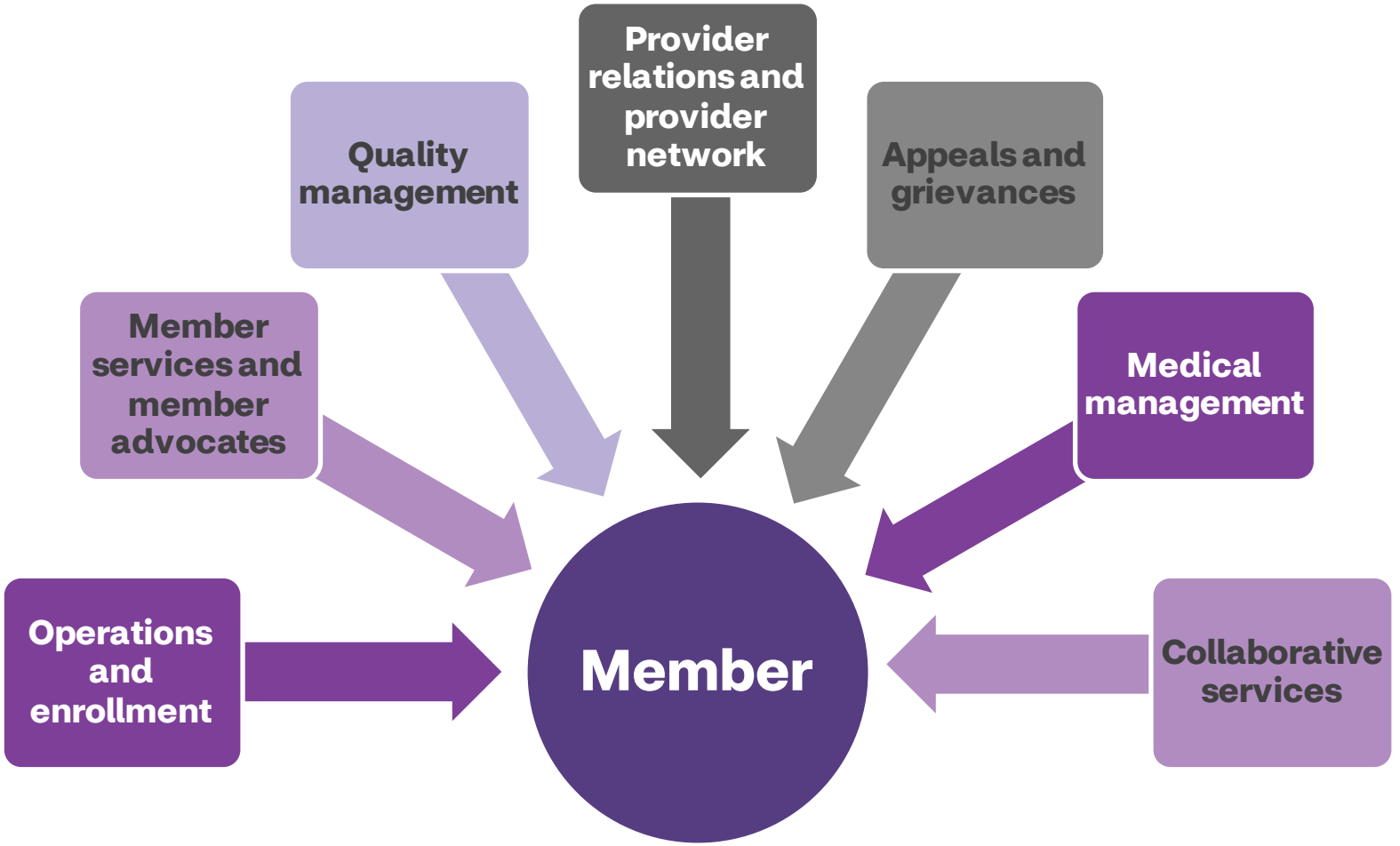
- Discuss the background of the MMA AND LTSS program
- Review the Aetna Better Health of Florida website
- Explain how to register for our secure provider portal and access our suite of electronic tools and resources
- Explain how to verify patient eligibility and locate plan benefits

We'll also:

- Review how to submit referrals and prior authorizations
- Identify the requirements for submitting clean claims and how to locate claims-related policies
- Discuss Aetna Better Health of Florida's compliance and quality management programs
- Discuss the importance of cultural competence in the health care environment and the role of the provider as a mandated reporter

Introduction

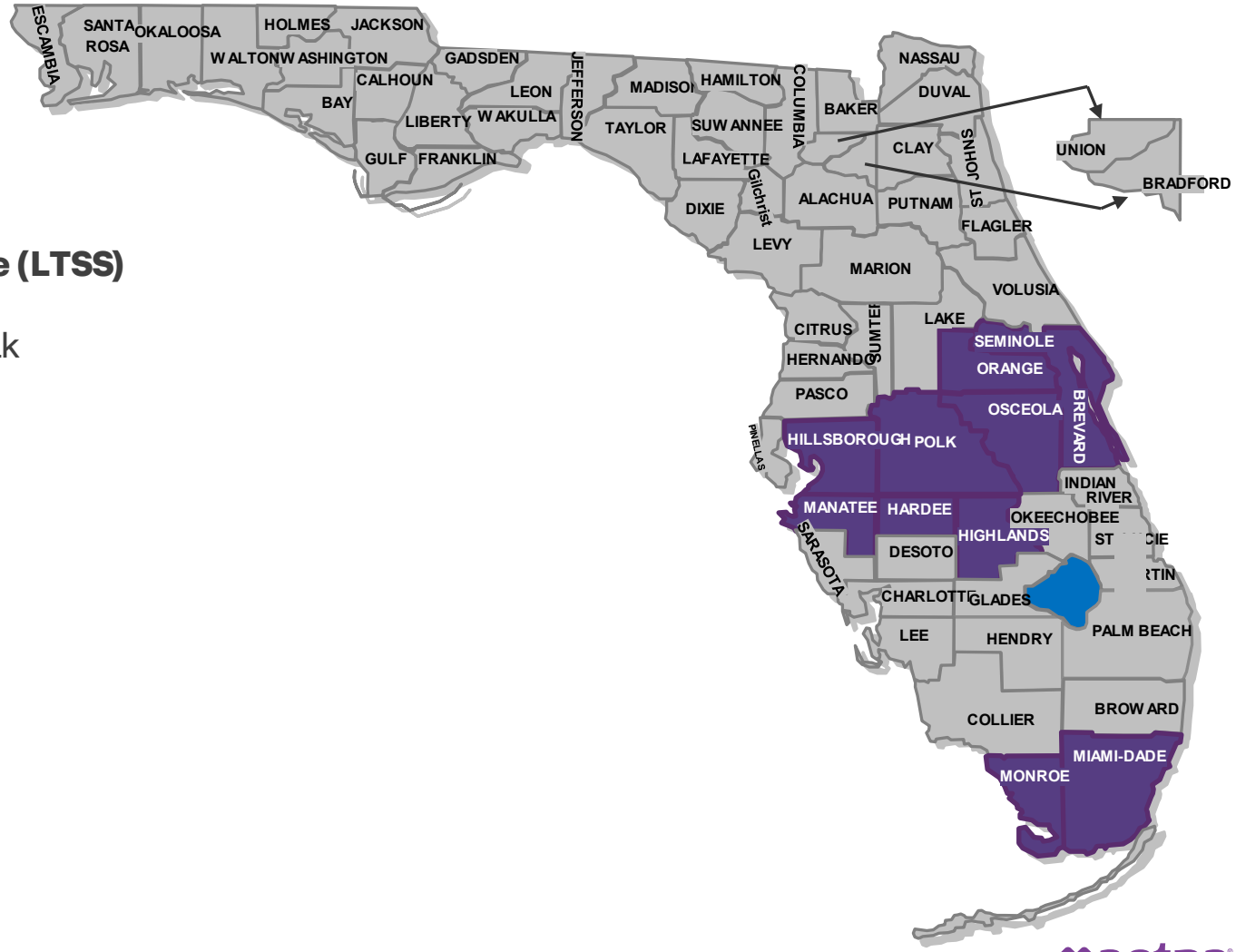
Our members - the center of what we do



Plan overview statewide

Medicaid (MMA) and Comprehensive Long-Term Care (LTSS)

Region 6: Hardee, Highlands, Hillsborough, Manatee, Polk
Region 7: Brevard, Orange, Osceola, Seminole
Region 11: Miami-Dade, Monroe



Aetna Better Health of Florida website

Providers can access the Aetna Better Health of Florida website at **AetnaBetterHealth.com/Florida**

There you'll find tools and resources to make doing business with Aetna quick and simple. We've listed a few of the tools and resources found on the For Providers tab below:

- Provider Directory
- Provider Manual
- Notifications and Newsletters
- Authorizations
- Document Library
- Pharmacy
- Practice Guidelines/Screening Tools
- Provider Education
- Secure Provider Portal
- HEDIS

Secure provider portal registration

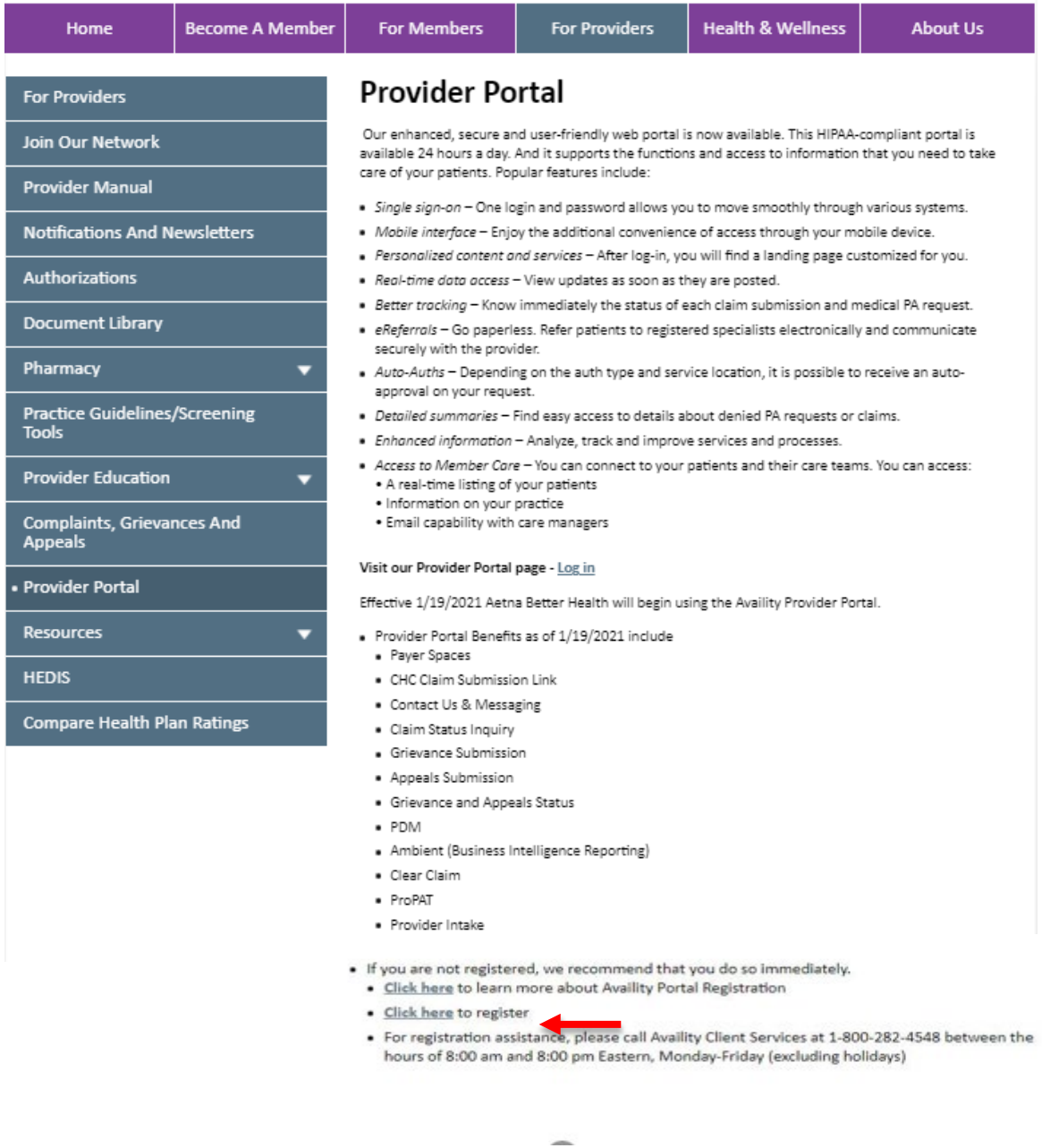
To register for access to the secure provider portal on Availity, simply follow these four easy steps:

1. Select the For Providers tab on the navigation bar at the top of our website.

2. Select Provider Portal from the menu on the left side of your screen.

3. Scroll to the bottom of the page and select Click here to register and follow the on-screen prompts to complete your registration.

4. Once logged into the Availity homepage, go to Payer Spaces on the navigation bar. Select Aetna Better Health from your payer list to access all available transactions and features.



Secure provider portal tools and resources

Availity Provider Portal Benefits include:

- Payer Spaces
- Claim Submission and Status transactions
- Contact Us & Messaging
- Grievance and Appeals transactions
- PDM
- Ambient (Business Intelligence Reporting)
- Clear Claim
- Prior Authorizations tools
- Provider Intake
- Dynamo (Case Management)

Additional transactions will be rolled out as follows:

- Eligibility and benefits inquiries – 4/29/21
- Enhanced Grievance & Appeals transactions – 7/1/21
- Panel roster – 7/1/21
- View EOB– 7/1/21
- Remittance viewer – 9/30/21

For access to the following features, please continue to use the Aetna Better Health of Florida provider portal until they transition to the secure provider portal on Availity (see roll-out dates displayed above).

- Eligibility & Benefits
- Panel Roster
- Remit PDF
- Provider Portal Registration Form
- Provider Portal Instructions

Provider manual

The provider manual contains plan policies, procedures and benefits. You'll also find general reference information such as the minimum standards of care required of Plan providers.

The most current version of the provider manual is available on **AetnaBetterHealth.com/Florida**.

To request a copy of the provider manual by email or mail, or for general questions, simply contact our Provider Relations Department:

Email: **FLMedicaidProviderRelations@Aetna.com**

Medicaid Member Services - **1-800-441-5501**
LTSS Member Services **- 1-844-645-7371**
(TTY 711)

Member rights and responsibilities

Understanding members' rights and responsibilities is vital to helping your patients and their families make informed health care decisions. We've provided a few examples below. For the full lists, please refer to the Member Rights and Responsibilities section of the provider manual.

Rights

A member has the right to know who is providing medical services and who is responsible for his or her care.

A member has the right to refuse any treatment, except as otherwise provided by law.

A member has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.

A member has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.

Responsibilities

A member is responsible for following the treatment plan recommended by the health care provider.

A member is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.

A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.

A member is responsible for following health care facility rules and regulations affecting member care and conduct.

Translation services

Interpreter services, including sign language for the hearing impaired, are available at no cost to members.

For more information regarding these services, please contact us by calling:

Medicaid Member Services - **1-800-441-5501**
LTSS Member Services **- 1-844-645-7371**

For members who are hearing impaired, the health plan will utilize the **711** Telecommunications Relay Service (TRS).

Provider education

Aetna Better Health of Florida is committed to offering ongoing training and education to all network providers.

Providers can access all educational content as well as a schedule of upcoming webinars on our website under the Provider Education tab.

There you'll find information on topics such as:

- Behavioral Health Trainings +
- Provider Orientations +
- Cultural Competency +
- Health Literacy +
- Project ECHO (Extension for Community Healthcare Outcomes) +
- Prematurity Symposium Presentations +

Provider credentialing

To learn more about the credentialing process, please refer to the Join our Network tab on our website. There you'll also find a list of our network vendors for specialty services, areas and products. Please contact the designated vendor to inquire about joining the Aetna Better Health of Florida network for one of the listed specialties.

Existing contracted facilities that wish to initiate credentialing of a new provider, please contact our Provider Relations Department by using the Provider Nomination Form found on our website. A valid CAQH number will be required.

Please allow 60 days for your request to be processed. After 60 days, to inquire about the status of your request, please email the provider's name and NPI to **FLMedicaidCredentialing@Aetna.com**.

Florida outreach team

Good communication among our providers and our plan administrators is key to the delivery of quality health care services to our members. To show our commitment to our members and provider community, Aetna Better Health of Florida has assembled an outreach team that is dedicated to:

- Coordinating, facilitating, and participating in Health and Wellness initiatives
- Increasing our knowledge of community resources for members
- Facilitating enrollment events
- Increasing our community visibility and connectivity
- Building collaborative community relationships
- Demonstrating our investment in the communities we serve through volunteerism

Eligibility and benefits

Continuity of care

Aetna Better Health of Florida shall be responsible for coordination of care for new Florida MMA and LTSS enrollees transitioning into the Plan.

Providers should continue to provide care during the transition period.

Aetna Better Health of Florida will honor documented authorization of ongoing covered services for a period of sixty (60) days after the effective date of enrollment.

Providers should bill claims to the health plan to which the Florida MMA and LTSS enrollee is assigned for the costs of continuation of such course of treatment by participating or non-participating providers.

Enrollees may continue to receive covered services from participating and non-participating providers beyond the sixty (60) day timeframe under certain circumstances. Please refer to the provider manual for more information regarding our continuity of care policies.

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Eligibility

To become a member with Aetna Better Health of Florida, a member must first be eligible for the Florida MMA and LTSS program. Benefits are predetermined by the State of Florida.

The Agency for Health Care Administration (AHCA) must approve a member's enrollment with Aetna Better Health of Florida.

To be eligible for Florida Medicaid, a person must:

- Be a resident of Florida
- Meet specific standards for financial income and resources
- Be a U.S. citizen or lawful U.S. resident

To be eligible for the Florida Comprehensive Long-Term Care Program, a person must:

- Be age 65 and over and eligible for Medicaid
- Be age 18 and over and eligible for Medicaid by reason of a disability
- Meet a nursing home level of care need as determined by CARES.

An enrollee's coverage with us starts on the first day of the month following approval.

Enrollment

For general information about our Medicaid and LTSS Plans, please contact us by calling:

Medicaid Member Services - **1-800-441-5501**
LTSS Member Services- **1-844-645-7371**

If your patient already has Medicaid, they can choose or change their Medicaid Health Plan by visiting the SMMC website at **FlMedicaidManagedCcare.com** or contact a SMMC Choice Counselor at **1-877-711-3662** (**TTY 1-866-467-4970**).

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Verifying eligibility

All participating and nonparticipating providers are encouraged to verify members' eligibility status before they deliver covered services.

The provider is responsible for verifying a member's current enrollment status before providing care.

Providers will not be reimbursed for services rendered to members who are no longer eligible.

Presentation of an Aetna Better Health of Florida ID card is not a guarantee of eligibility.

Eligibility can be verified in the following ways:

- Contact our MMA Member Services Department by calling **1-800-441-5501**
- Contact our LTSS Member Services Department by calling **1-844-645-7371**
- Access our secure provider portal -

  AetnaBetterHealth.com/Florida/providers/provider-portal

Effective 4/29/2021 all eligibility & benefits transactions will transition to Availity.

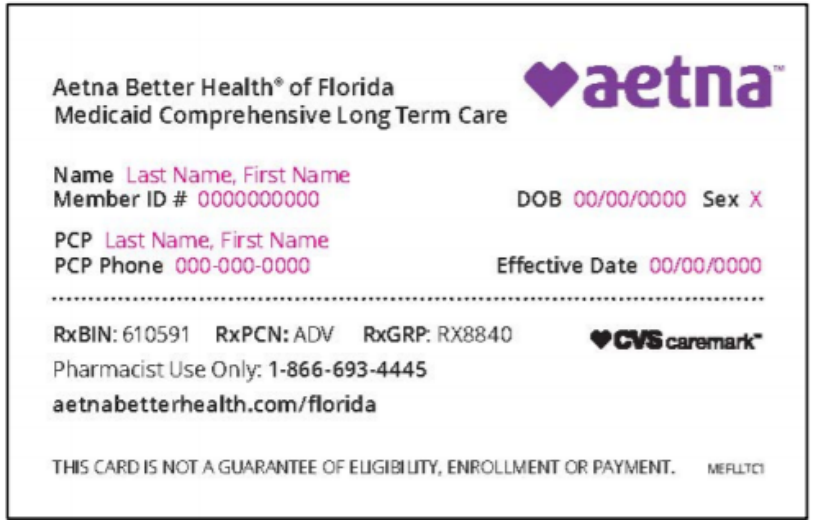
Member ID card

Aetna Better Health of Florida issues an identification card for each member.

The member ID card contains the following information:

- Member's name
- Member's ID number
- Member's date of birth
- Member's gender
- Member's effective date
- Claims address

Some Sample ID Cards:



Managed Medicaid covered services

The table below provides the listing of if the covered services*.

Covered Services	Covered Services
Ambulance Services	Emergency service to hospital $0 Copay
Behavioral Health Services (Inpatient, outpatient, physician services, community mental health, targeted case management for children & adults, intensive targeted case management for adults)	**Beacon Health Options** (formerly PsychCare) Toll Free: **1-800-221-5487** Fax: **1-800-370-1116** Medical, social & educational resources Services must be recommended by primary care physician or psychiatrist Substance abuse $0 Copay
Child Health Check-Up Services Health screening evaluation that shall consist of: comprehensive health and developmental history (including assessment of past medical history, developmental history and behavioral health status); comprehensive unclothed physical exam; developmental assessment; nutritional assessment; appropriate immunizations; laboratory testing (including blood lead testing); health education (including anticipatory guidance); dental screening (including a direct referral to a dentist for members beginning at age three or earlier as indicated); vision screening including objective testing as required; diagnosis and treatment; and referral and follow-up as appropriate.	Up to age 20 MediKids - age 1-4 $0 Copay
Chiropractic Services Up to 24 visits per year	$0 Copay
Circumcision	See expanded benefits below $0 Copay
Diabetic Supplies	$0 Copay

Covered Services	Covered Services
Durable Medical Equipment & Medical Supplies – (DME) • Medical or surgical items that are consumable, expendable, disposable or non-durable & are appropriate for use in the patient's home • Must have prescription or hospital discharge orders • Documentation and Plan of Care must be signed by/dated by physician with specific term, duration & diagnosis • Prior-authorize DME purchases over $500 allowable, • rentals, items that are not on the Medicaid Fee schedule • Some services limited to under 21 years of age only	$0 Copay
Emergency Services, including Emergency Behavioral Health Services (Member has access to par & non-par Providers) • Pre-hospital and hospital based trauma and emergency services • Post-stabilization care Behavioral Health Emergency hotline available to all members 24 hours per day, 7 days per week	$0 Copay Behavioral Health Hotline for Members: **Beacon Health Options** (formerly PsychCare) Toll Free: **1-800-221-5487**
Family Planning Services (Member has access to par & non-par Providers) • Restrictions for members under the age of 18 based on marital status, parental consent and pregnancy or in the opinion of the physician, the member may suffer health hazards if the services are not provided. Not covered: Infertility or elective abortion	$0 Copay
Flu Shots • Covered for up to 18 years of age under the Vaccine for Children • (VFC) program • State provides immunizations directly to the Provider • For ages 19-20, ABH covers the flu shot and the Provider should bill ABH if administered	$0 Copay
Hearing Services • Hearing exam and/or hearing aid (limited number and /or selection of hearing aid) if medically necessary	**HearUSA** Toll Free: **1-800-731-3277** $0 Copay

For a comprehensive review of all MMA benefits, please refer to the Managed Medicaid covered services section of the provider manual.

MMA expanded benefits

Medical expanded benefits

Service	Description	Coverage/Limitations	Prior Authorization
Art Therapy	Therapy using art to help members recover from or cope with health problems	Covered as medically necessary for members 21 and older	Yes
CVS Discount Program	20% discount card on certain OTC items	3 cards per household for length of enrollment	No
Doula Services	Home visits for care before baby is born, care after baby is born, and newborn visit by Doula	No limit for pregnant female members 14 to 55 years of age	Yes
Equine (Horse) Therapy	Therapy using horses to help members recover from or cope with health problems	Covered as medically necessary For members 21 and older Ten (10) sessions per year	Yes
Home Delivered Meals – After discharge from a facility	Meals provided to members after hospital or nursing home discharge	For members 21 and older 10 meals delivered to the home Limited to 2 discharges per year	Yes
Home Health Nurse and Aide Services	Skilled nurse or home health aide services in your home	No limit for non-pregnant members 21 and older	Yes
Home Visit by a Clinical Social Worker	Visits by clinical social workers in your home or hospice setting	48 visits per year for members 21 and older	Yes
Hypoallergenic Bedding	$100 allowance for hypoallergenic bedding (sheets, mattresses covers) for members with allergic asthma	1 set of bedding for members 21 and older	Yes

Behavioral health expanded benefits

Service	Description	Coverage/Limitations	Prior Authorization
Day Treatment	Day Care Services for behavioral health	Covered as medically necessary No limit for members 21 and older	Yes
Evaluation and testing	Different types of testing, evaluations, assessments, screenings, computer, and mental health exams	Covered as medically necessary No limit for members 21 and older	Yes
Group Therapy	Therapy given with other people under the supervision of a therapist	Covered as medically necessary No limit for members 21 and older	No

For a comprehensive review of all Medicaid and Behavioral health expanded benefits, please refer to the Managed Medicaid expanded services section of the provider manual.

Long Term Care covered services

Service	Description	Prior Authorization
Companion Care	This service helps fix meals, do laundry and light housekeeping	Yes
Adult Day Health Care	Supervision, social programs, and activities provided at an adult day care center during the day.	Yes
Assistive Care Services	These are 24-hour services if member lives in an adult family care home or an assisted living facility	Yes
Assisted Living	These are services that are usually provided in an assisted living facility. Services can include housekeeping, help with bathing, dressing, and eating, medication assistance, and social programs.	Yes
Attendant Nursing Care	Nursing services and medical assistance provided in member's home to help the member manage or recover from a medical condition, illness, or injury	Yes
Behavioral Management	Services for mental health or substance abuse needs	Yes
Caregiver Training	Training and counseling for the people who help take care of the member	Yes
Care Coordination/ Case Management	Services that help you get the services and support member need to live safely and independently. This includes having a case manager and making a plan of care that lists all the services member need and receive.	Yes
Home Accessibility/ Adaptation Services	This service makes changes to member's home to help member live and move in member's home safely and more easily. It can include changes like installing grab bars in member's bathroom or a special toilet seat. It does not include major changes like new carpeting, roof repairs, plumbing systems, etc.	Yes
Home Delivered Meals	This service delivers healthy meals to member's home	Yes
Homemaker Services	This service helps member with general household activities, like meal preparation and routine home chores	Yes

Service	Description	Prior Authorization
Hospice	Medical care, treatment, and emotional support services for people with terminal illnesses or who are at the end of their lives to help keep them comfortable and pain free. Support services are also available for family members or caregivers.	Yes
Intermittent and Skilled Nursing	Extra nursing help if member do not need nursing supervision all the time or need it at a regular time	Yes
Medical Equipment and Supplies	Medical equipment is used to help manage and treat a condition, illness, or injury. Medical equipment is used over and over again, and includes things like wheelchairs, braces, walkers, and other items. Medical supplies are used to treat and manage conditions, illnesses, or injury. Medical supplies include things that are used and then thrown away, like bandages, gloves, and other items.	Yes
Medication Administration	Help taking medications if member can't take medication by member	Yes
Medication Management	A review of all of the prescription and over-the- counter medications member are taking	Yes
Nutritional Assessment/Risk Reduction Services	Education and support for member and member's family or caregiver about member's diet and the foods member need to eat to stay healthy	Yes
Nursing Facility Services	Nursing facility services include medical supervision, 24-hour nursing care, help with day- to-day activities, physical therapy, occupational therapy, and speech-language pathology	Yes
Personal Care	These are in-home services to help member with: • Bathing • Dressing • Eating • Personal hygiene	Yes

For a comprehensive review of all LTSS benefits, please refer to the Long Term Care covered services section of the provider manual.

LTSS expanded benefits

Expanded benefits are extra services we provide to the member at no cost. Talk to the case manager about to obtain more information on the expanded benefits.

Service	Description	Coverage/Limitations	Prior Authorization
Assisted Living Facility/Adult Family Care Home-Bed Hold Days	Health plan will pay to hold member's bed for 30-days when admitted to a the hospital or nursing home	30-day bed hold for members who live in an ALF or AFCH and are age 18 and older	No
Home Delivered Meals-Disaster/ Preparedness	Ten (10) shelf stable meals delivered prior to hurricane or other disaster	One (1) food delivery per year ages 21 and over	No
Housing Assistance	For community based members to assist with a health crisis, personal loss, rent, housing or utilities	$250 per member per year members age 18 and older	Prior authorization is needed
Non-emergency Transportation - Non-Medical Purposes	Weekly social round trip transportation within county of residence for going to the bank, grocery shopping, church	Weekly within the county that you live for members age 21 and older	No
Transitional Assistance	Assistance with move from a nursing home to the community; help with housing, furnishings, supplies and moving expenses	$5000 per lifetime for members age 18 and older	Prior authorization is needed

Mixed services

The services below are covered in both the Long Term Care and the Managed Medicaid Assistance programs.

When covered by both the enrollee's Long Term Care and Managed Medicaid Assistance plans, these services are the responsibility of the Long Term Care plan.

Assistive care	Occupational therapy
Attendant nursing care	Physical therapy
Hospice	Respiratory therapy
Intermittent skilled nursing	Speech therapy
Personal care	Transportation

Immunizations

PCPs must provide all covered immunizations to members.

PCPs need to be registered with the Vaccines for Children (VFC) Program. The VFC program supplies providers with vaccines for children ages 0 through 18 at no charge. We will reimburse providers for the administrative fee for these vaccines.

For more information on immunizations, visit the Immunizations section under the Health & Wellness tab of our website or refer to the provider manual.

Pharmacy coverage

For the Florida MMA list of covered drugs, please access our searchable formulary in the Pharmacy section under the For Providers tab of our website.

Medically necessary drugs on this list are generally covered under the plan.

Members can fill their prescriptions at any in-network pharmacy.

Aetna Better Health of Florida's PBM is CVS/Caremark.

For questions regarding prescription coverage or our formulary, please contact us by calling:

Medicaid Member Services - **1-800-441-5501**
LTSS Member Services **- 1-844-645-7371**
(TTY 711)

Child health checkup

A child health checkup is a regularly scheduled comprehensive, preventive health screening service for children from birth through age 21.

The screening generally includes the following:

- Comprehensive health and developmental history, including assessment of past medical history, developmental history and health status
- Nutritional assessment
- Developmental assessment
- Comprehensive physical examination
- Dental screening, including a dental referral, when required
- Vision screening, including objective testing, when required
- Hearing screening, including objective testing, when required
- Laboratory test, including blood lead testing, when required
- Appropriate immunizations
- Health education and anticipatory guidance
- Diagnosis and treatment
- Referral and follow-up, as appropriate

PCP assignments and changes

Members may choose any primary care physician (PCP) that is participating in the Aetna Better Health of Florida's network. If a member does not choose a PCP, one will be assigned by the Plan.

For PCP change requests, please contact Member Services by calling **1-800-441-5501** Monday through Friday from 7:30 AM to 7:30 PM ET.

PCP change requests received on or before the 15th of the month will be effective immediately. Requests received after the 15th of the month will be effective on the first day of the following month.

PCPs should not cancel appointments or deny care if the member is assigned to an incorrect PCP. If the member has an existing appointment or has presented for care, the PCP is encouraged to contact Member Services to request an immediate provider change.

Timely access standards

Practitioner type	Appointment type	Accessibility standard
Primary Care Practitioner (PCP)	Preventive care & routine (non- urgent)	Within thirty (30) days of a request
	Urgent care	Within forty-eight (48) that do not require prior authorization or within ninety-six (96) that do require prior authorization
	Non-urgent	Within thirty (30) days of a request
	Emergency services – non-life threatening	Immediately or referred to ER facility
Specialty Referral	Preventive care & routine (non- urgent)	Within sixty (60) days of a request after the appropriate referral is received by the specialist.
	Urgent care	Within forty-eight (48) that do not require prior authorization or within ninety-six (96) that do require prior authorization
	Non-urgent	Within thirty (30) days of a request after the appropriate referral is received by the specialist.
	Emergency services-non-life threatening	Within 24 hours
Behavioral Health/Substance Abuse	Preventive care & routine (non- urgent)	Within seven (7) days post discharge from an inpatient behavioral health admission for follow-up behavioral health treatment or within fourteen (14) days for initial outpatient behavioral health treatment
	Routine/follow-up (non- urgent, symptomatic conditions)	Within seven (7) days post discharge from an inpatient behavioral health admission for follow-up behavioral health treatment or within fourteen (14) days for initial outpatient behavioral health treatment
	Urgent care	Within forty-eight (48) that do not require prior authorization or within ninety-six (96) that do require prior authorization
	Emergency Services-non-life threatening	Within forty-eight (48) that do not require prior authorization or within ninety-six (96) that do require prior authorization
Lab and Radiology Services	Preventive care & routine (non- urgent)	Within fourteen (14) days of a request
	Urgent care	Within forty-eight (48) that do not require prior authorization or within ninety-six (96) that do require prior authorization

Prior authorizations and referrals

Hospital authorizations and peer to peer reviews

Hospital authorizations

All hospital admissions and observation stays require authorization.

When a member is admitted, hospitals are required to contact the Member Services Department within 24 hours of the admission for both scheduled or emergency admissions by calling **1-800-441-5501.**

Clinical information should be faxed to **1-844-878-3583**.

Peer to peer requests with the Medical Director

The request for a peer-to-peer review between the treating physician and the Medical Director must be received within two business days of the issuance of the verbal denial independent of the discharge date.

If a concurrent peer-to-peer review request is received more than two business days after the issuance of the verbal denial, the treating physician will be advised to follow the appeal process.

Prior authorizations

Providers can submit electronic prior authorizations for medically necessary services by logging into our secure provider portal on Availity.

Please remember that *emergencies do not require prior authorization.*

When submitting authorization requests via Availity, Elective and Urgent are the only applicable options for the Admission Type (level of service) field for Aetna Better Health of Florida. **Providers can attach clinical documentation to electronic authorization requests**.

Turn around times for processing requests are as follows:
Standard – 14 calendar days
Urgent – 72 hours

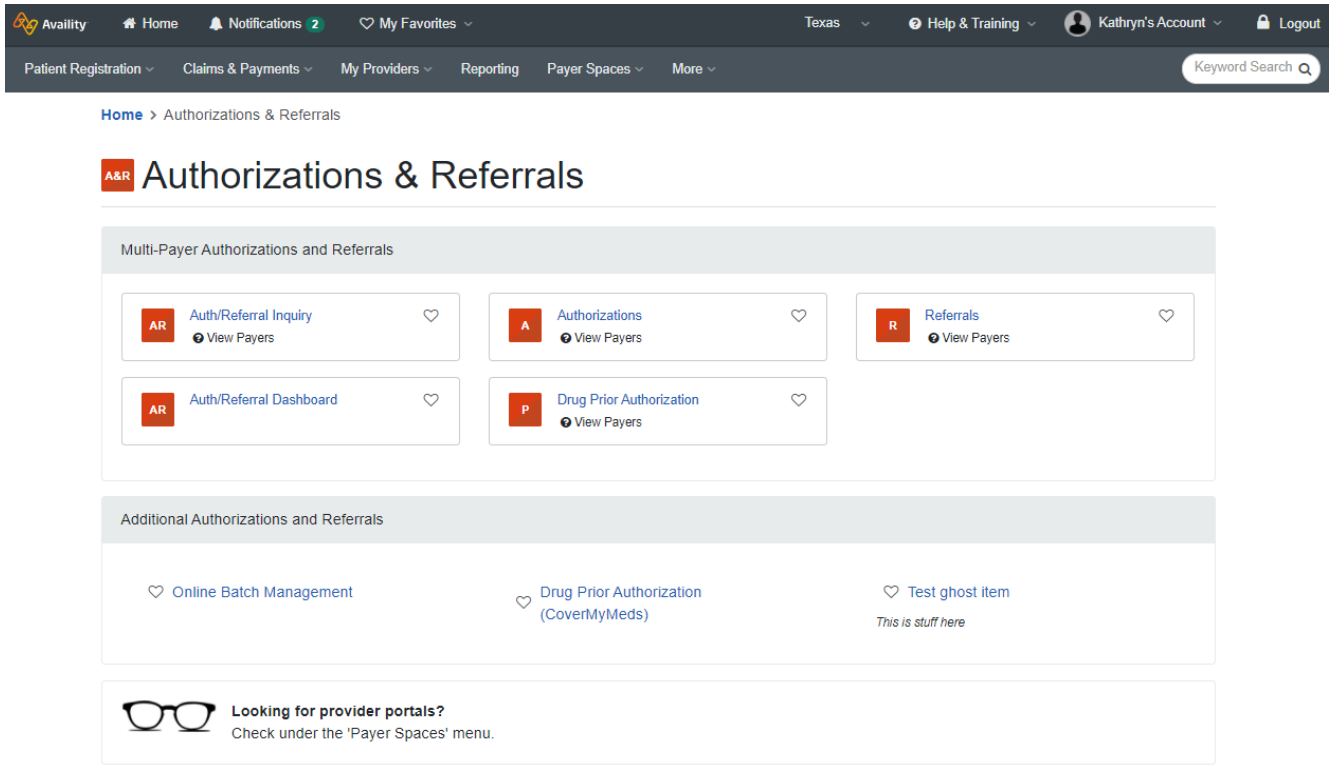
To check the status of a prior authorization, please login to Availity or by calling:

MMA **1-800-441-5501**

LTSS **- 1-844-645-7371**

(TTY 711) Monday through Friday from 8:00 AM to 7:00 PM ET.

To determine which services require prior authorization, please review our ProPat Auth Lookup Tool on our secure provider portal



Prior authorizations cont.

If you are unable to submit your requests electronically, you can submit your request in the following ways:

Authorization Department:

- MMA- **1-800-441-5501**
- LTSS- **1-844-645-7371**
- Fax- **1-860-607-8056**

Providers only need to submit one form for all lines of business. The Prior Authorization Form can be found on **AetnaBetterHealth.com/Florida**.

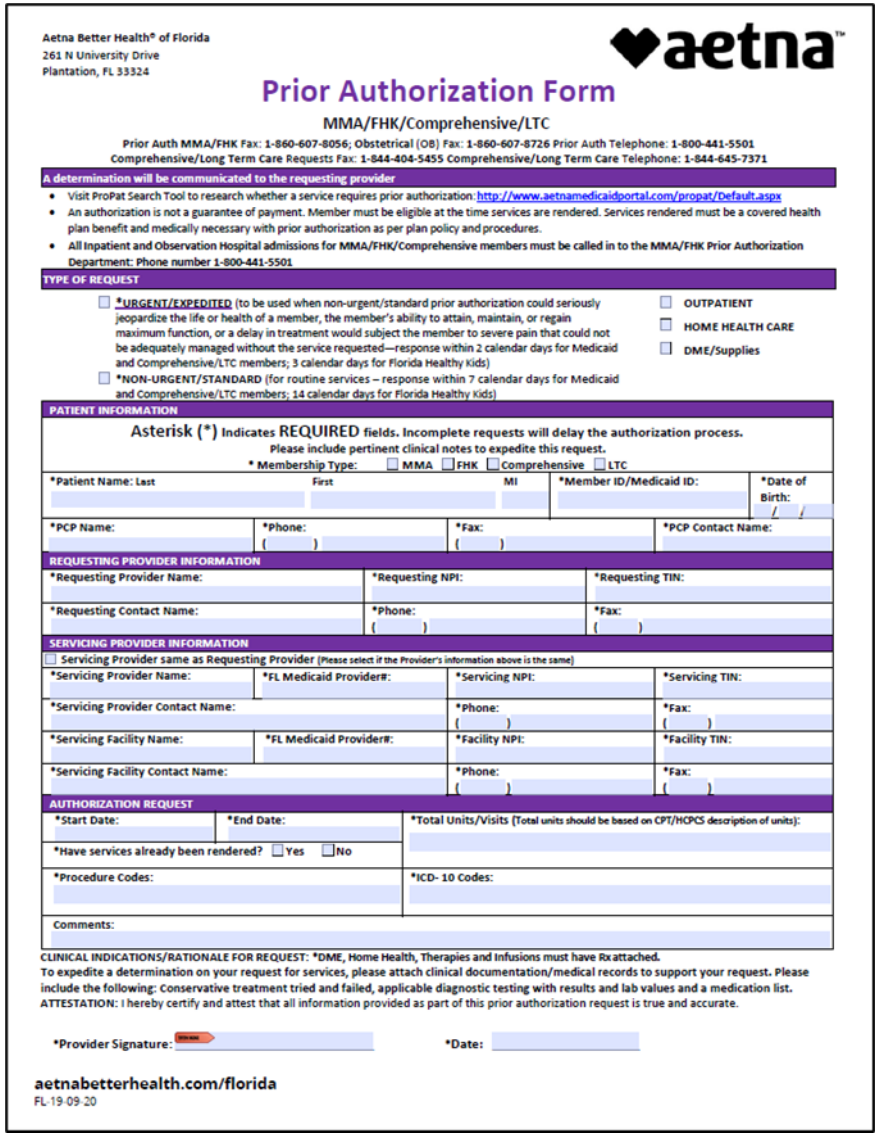
If you are attaching clinicals or scripts, please fax your request to:

- Medical Prior Authorization **1-860-607-8056**
- Obstetrics Prior Authorization **1-860-607-8726**
- Pharmacy Prior Authorization **1-855-799-2554**
- Long-Term Care Prior Authorization **1-844-404-5455**

Prior authorizations for MRI, PET, CT, Nuclear Medicine and Interventional Pain Management are managed by eviCore and can be requested via phone, fax or web portal:

- Phone **1-888-693-3211**
- Fax **1-844-822-3862**
- Web **www.eviCore.com**

Urgent/expedited requests should be clearly labeled on the Prior Authorization Form.



Aetna Better Health® of Florida
261 N University Drive
Plantation, FL 33324

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Prior Authorization Form

MMA/FHK/Comprehensive/LTC

Prior Auth MMA/FHK Fax: 1-860-607-8056; Obstetrical (OB) Fax: 1-860-607-8726 Prior Auth Telephone: 1-800-441-5501
Comprehensive/Long Term Care Requests Fax: 1-844-404-5455 Comprehensive/Long Term Care Telephone: 1-844-645-7371

A determination will be communicated to the requesting provider

- Visit ProPat Search Tool to research whether a service requires prior authorization: http://www.aetnamedicaidportal.com/propat/Default.aspx
- An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services rendered must be a covered health plan benefit and medically necessary with prior authorization as per plan policy and procedures.
- All Inpatient and Observation Hospital admissions for MMA/FHK/Comprehensive members must be called in to the MMA/FHK Prior Authorization Department: Phone number 1-800-441-5501

TYPE OF REQUEST

☐ *URGENT/EXPEDITED (to be used when non-urgent/standard prior authorization could seriously jeopardize the life or health of a member, the member's ability to attain, maintain, or regain maximum function, or a delay in treatment would subject the member to severe pain that could not be adequately managed without the service requested—response within 2 calendar days for Medicaid and Comprehensive/LTC members; 3 calendar days for Florida Healthy Kids)
☐ *NON-URGENT/STANDARD (for routine services – response within 7 calendar days for Medicaid and Comprehensive/LTC members; 14 calendar days for Florida Healthy Kids)

☐ OUTPATIENT
☐ HOME HEALTH CARE
☐ DME/Supplies

PATIENT INFORMATION

Asterisk (*) Indicates REQUIRED fields. Incomplete requests will delay the authorization process.
Please include pertinent clinical notes to expedite this request.
* Membership Type: ☐ MMA ☐ FHK ☐ Comprehensive ☐ LTC

*Patient Name: Last	First	MI	*Member ID/Medicaid ID:	*Date of Birth: / /

*PCP Name:	*Phone: ( )	*Fax: ( )	*PCP Contact Name:

REQUESTING PROVIDER INFORMATION

*Requesting Provider Name:	*Requesting NPI:	*Requesting TIN:
*Requesting Contact Name:	*Phone: ( )	*Fax: ( )

SERVICING PROVIDER INFORMATION

☐ Servicing Provider same as Requesting Provider (Please select if the Provider's information above is the same)

*Servicing Provider Name:	*FL Medicaid Provider#:	*Servicing NPI:	*Servicing TIN:
*Servicing Provider Contact Name:		*Phone: ( )	*Fax: ( )
*Servicing Facility Name:	*FL Medicaid Provider#:	*Facility NPI:	*Facility TIN:
*Servicing Facility Contact Name:		*Phone: ( )	*Fax: ( )

AUTHORIZATION REQUEST

*Start Date:	*End Date:	*Total Units/Visits (Total units should be based on CPT/HCPCS description of units):
*Have services already been rendered? ☐ Yes ☐ No		
*Procedure Codes:		*ICD- 10 Codes:
Comments:		

CLINICAL INDICATIONS/RATIONALE FOR REQUEST: *DME, Home Health, Therapies and Infusions must have Rx attached.
To expedite a determination on your request for services, please attach clinical documentation/medical records to support your request. Please include the following: Conservative treatment tried and failed, applicable diagnostic testing with results and lab values and a medication list.
ATTESTATION: I hereby certify and attest that all information provided as part of this prior authorization request is true and accurate.

*Provider Signature: *Date:

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LTSS prior authorizations

All services for the Comprehensive Long-Term Care program require a review and approval by the Case Manager.

Service planning must involve the member and member representative working cooperatively with the member's Case Manager.

Service authorizations must reflect services specified in the plan of care.

Prior authorization review determinations will be based solely on the information obtained at the time of the review.

If needed, a Medical Director will review service requests for medically necessity before a denial of service authorization occurs.

Referrals

The PCP is responsible for coordinating the provision of specialist services. The specialist and PCP work together to coordinate medical care for the member.

A PCP referral is not required for the following Direct Access services: Chiropractic, Dermatology (5 visits/year), routine Podiatric care, Optometry, Behavioral Health and OB/GYN.

A PCP referral is required for all other specialist services.

Referrals can be submitted electronically via our secure portal. If manual submission is preferred, providers can download a copy of the referral form on our website under the Authorizations tab.

Specialists are asked to provide the referring PCP with a written report within 10 business days of rendering specialty services.

Specialists are required to refer the member back to their PCP if they determine the member needs to be seen by another specialist.

Claims

EFT/ERA

Change Healthcare is the preferred EFT/ERA vendor for Aetna Better Health of Florida.

EFT (electronic funds transfer)

EFT improves the consistency of your payments by providing fast, accurate and secure payments directly into your bank account.

To enroll in EFT, fill out the enrollment form located on our website and submit it via our secure fax to **1-844-209-2060** or by email to **FLFinanceEFTEnrollment@aetna.com**.

ERA (electronic remittance advice)

An electronic file (also know as an 835 file) that contains claims payment and remittance information. The transmission of these files reduces manual posting of claims payment by allowing the user to upload financial data directly into your office's system. This process eliminates the need for paper explanation of benefits (EOBs).

To enroll in ERA, fill out the enrollment form located on the ABHFL website and submit it via our secure fax to **1-844-235-1340** or by email to **FLMedicaidProviderRelations@Aetna.com**.

Please allow 10-15 business days for processing once your enrollment form is received. We'll send a confirmation letter to your office indicating the process has been completed.

Claims submissions

Please refer to the Claims and Encounter Submission Protocols and Standards section of the provider manual for information on filing clean claims to ensure prompt payment.

We also encourage you to review the Claims Information section under the Resource tab of our website. There you'll also find provider communication and bulletins with updated policies and other important claims-related information.

Clean claims can be sent to:

Aetna Better Health of Florida
P.O. Box 63578
Phoenix, AZ 85082-1925
Claims payer ID for EDI – 128FL
Real time payer ID - ABHFL

Need help? Simply reach out to our Claims Inquiry/Claims Research team (CICR) by calling MMA Provider Services at **1-800-441-5501** or LTSS Provider Services at **1-844-645-7371** for assistance with:

- Claims related questions, inquiries and reconsiderations
- Reviewing claims or remittance advices
- Assistance with claims-related prior authorization questions
- Viewing recent updates
- Locating forms

Claims and Encounter Submission Protocols and Standards

Claims and encounter submission protocols and standards are available in this section. Additional claims and encounter submission protocols and standards are available through provider communications and bulletins. These communications and bulletins may be found on the Aetna Better Health of Florida website **AetnaBetterHealth.com/Florida.** Providers shall submit claims in accordance with applicable state and federal laws. Untimely claims will be denied when they are submitted past the timely filing deadline. Unless otherwise stated in the Provider agreement, the following guidelines apply.

Timely Filing and Prompt Pay Guidelines Grid

Provider / Claim Type	Guideline
Plan Participating Providers	Provider shall mail or electronically transfer (submit) the claim within **180 days** after the date of service or discharge from an inpatient admission. (F.S. 641.3155)
Non-Participating Providers	Provider shall mail or electronically transfer (submit) the claim within **365 days** after the date of service or discharge from an inpatient admission. (SMMC Contract) (Section VIII.D)(E)(2)
Plan as Secondary Payor	When the Managed Care Plan is the secondary payer, the provider must submit the claim within **ninety (90) calendar days** after the final determination of the primary payer. (SMMC Contract) (Section VIII)(E)(1)(h)
Medicare Crossover	When the Managed Care Plan is the secondary payer to Medicare, and the claim is a Medicare cross over claim, these must be submitted within **36 months** of the original submission to Medicare. (SMMC Contract) (Section VIII) (E)(2)(d)(2)
Corrected Claims	Provider shall mail or electronically transfer (submit) the corrected claim within **180 days** from the date of service or discharge from an inpatient admission. (F.S. 641.3155)
Return of requested additional information (itemized bill, ER records, med records, attachments)	A provider must submit any additional information or documentation as specified, within **thirty-five (35) days** after receipt of the notification. Additional information is considered received on the date it is electronically transferred or mailed.
	Aetna Better Health cannot request duplicate documents. (F.S. 641.3155(2)(c)(2)

Claims resubmissions and reconsiderations

Resubmitted claims may be sent electronically or by mail.

When filing a resubmission, please write “Resubmission” at the top of the claim.

Submit all claim lines, not just the line being corrected.

When submitting a corrected or voided paper claim:

- UB04 claims must include the appropriate bill type (xx7)
- CMS1500 claims must include the appropriate bill frequency code –7 for corrected and 8 for voided - and the original claim number.

Send paper claims for reconsideration with attached documentation to:

Aetna Better Health of Florida
P.O. Box 63578
Phoenix, AZ 85082-1985

Send electronic claims for reconsideration through your EDI vendor.

Balance billing

For covered services, Providers shall not balance bill Members any amount in excess of the contracted amount in their provider agreement.

Providers shall accept payment from Aetna Better Health of Florida for covered services provided to Aetna Better Health of Florida Members in accordance with the reimbursement terms outlined in the provider agreement.

For more information on balance billing, please refer to Florida Statutes 641.3154 and 641.3155 (5)a.(8).

Providers shall not charge members for missed appointments.

Overpayment recovery

Providers are required to return identified overpayments to the Plan within 60 calendar days after the overpayment is identified.

Payment must be returned to the address below along with written notice explaining the reason for returning the payment:

Aetna Better Health of Florida
Provider Finance Department
4500 E Cotton Center Blvd
Phoenix, AZ 85040

If the plan identifies that a claim is overpaid, the provider will receive a letter via U.S. mail from the plan requesting the return of monies paid in error in accordance with Florida statute.

Providers can access and view their overpayment recovery detail under the Tasks section of our secure provider portal.

For all overpayment questions or concerns, please email us at **FLMedicaidProviderRelations@Aetna.com** or by mail via the address above.

Provider Appeals - Medical necessity reconsideration

If a Provider does not agree with a denial for lack of medical necessity, he/she may request a reconsideration of the decision by providing additional information in one of two ways:

- Request a Peer-to-Peer Review with the Medical Director who made the decision by calling the Peer-to-Peer coordinator at **1-959-299-7999**
- By providing additional information by phone at **1-800-447-3725**, by fax to **1-860-607-7894** or by mail to:

  Aetna Better Health of Florida
  Florida Medical Management
  PO Box 81040
  5801 Postal Road
  Cleveland, OH 44181

Provider Appeals - Medical necessity reconsideration cont.

Reconsiderations of prior authorization decisions must be:

- Received within five (5) business days of the date the denial of coverage determination was issued
- Received prior to services being rendered
- Received prior to the receipt of a claim or request for an appeal

Hospital concurrent review reconsideration requests for peer-to-peer review must be received within two (2) business days of the verbal denial being issued.

Quality management and compliance

Utilization management

Our utilization management program helps our members access medically necessary health care services in the most cost-effective setting under their benefit package.

Our UM decision-making process is based on consistent application of appropriate criteria and policies rather than financial incentives.

- UM decisions are based only on appropriateness of care and service and the existence of coverage.
- We do not reward practitioners, providers or other individuals conducting utilization review for issuing denials of coverage or service care.
- The compensation that we pay to practitioners, providers and staff assisting in utilization related decisions does not encourage decisions that result in underutilization or barriers to care or service.

For more information on our Utilization Management program, please refer to the Authorizations section under the For Providers tab of our website.

Care and disease management - Medicaid

Disease management
Aetna Better Health of Florida has disease management programs for members with conditions such as asthma, cancer, COPD, dementia, diabetes, and end of life issues. These programs give educational support and are set up by the member and their provider with the help of a case manager.

Integrated care management
Members who have a difficult or serious health problem may join our integrated care management program. They'll work with nurses or social workers who are trained in case management. They help members and their doctors with their needs. They also help members find community programs. For more information, please call Provider Services at **1-800-441-5501 (TTY 711)** and ask to speak with a case manager.

Our integrated care management and disease management programs are to help members manage lasting illnesses and diseases. Members and their doctor will work with a case manager. We mail materials to the member to help them manage their condition. These services are set up for the member with the help of their provider.

How can a member enroll in the program?
If a member has a long-term condition, we will sign them up for our disease management program. This could be a lasting illness like asthma or diabetes. The member can stay on the program or close the case at their discretion. Please contact Provider Services for inquiries.

Care and disease management – Comprehensive Long Term Care

Members will have their own case manager to help coordinate the services they need. Their case manager will work with their provider to put a plan together for their needs.

The first step is for the member to visit their doctor at least once a year. Then, work with their doctor. The member and their provider can choose which tests or shots are right for them. Through regular visits, you and the member can better protect them against disease. If you need help assisting a member with this program, call Provider Services at **1-844-645-7371 (TTY 711)**.

Care Unify

Care Unify is a web-based solution that aggregates multiple data sources in one location. The tool offers a 360° panel view that offers a detailed and organized look at member populations and includes a patient profile dashboard.

Care Unify platform value-based benefits:

- Provides an organized look at populations of members and each individual member via one source member intelligence
- May supplement health plan data and information with that from providers
- Promotes optimal patient care – it fosters continuity of care across team members in various care settings, can eliminate duplication of effort, and promotes best practices
- Enables access to HIE generated "near real time" ADT (admission, discharge and transfer) information, enabling timely member follow-up and transition of care management
- Supports goals of the health plan, including HEDIS metric performance and value based contracting arrangements with your providers

Care Unify patient management alerts include:

- Quality gaps in care reports, total costs of care data
- Transitions of care
- Health information exchanges (admission, discharge, transfer, lab data)
- High-risk and complex patient identification
- Social determinants of health
- Health plan analytics and claims information

For questions regarding the tool, please contact MMA Provider Services at **1-800-441-5501,** LTSS Provider Services at **1-844-645-7371** or by emailing **FLMedicaidProviderRelations@Aetna.com**.

Medicaid Provider Incentive Program (MPIP)

Primary Care Physicians (PCP)- includes pediatricians, family practitioners, and general practitioners regardless of specialty or board certification

Recognized as a Patient Centered Medical Home

- National Committee for Quality Assurance (NCQA), Level 2
- Accreditation Association for Ambulatory Health Care (AAAHC)
- The Joint Commission (TJC)
- Utilization Review Accreditation Commission (URAC)

Offers care after hours or on the weekend

Panel size >= 100, based on current members assigned < age 21

ER utilization < 650 annual visits per 1000 members < age 21

HEDIS

- Meets or exceeds NCQA Medicaid 50th percentile for Lead Screening
- NCQA Medicaid 50th percentile for Child Access (CAP) for at least 75% of the age bands in which the provider group has membership

Excludes Medical School Faculty Providers, Federally Qualified Health Centers, Rural Health Clinics or County Health Departments

OBGYN Qualifications at the Group/Practice

Performed at least 10 deliveries during the calendar year

C-section rate < 35% during the calendar year

HEDIS

- Meets or exceeds NCQA Medicaid 75th percentile for Frequency of Ongoing Prenatal Care
- Meets or exceeds NCQA National Medicaid Mean for Postpartum Care

Pediatric Specialists Qualifications- physicians who are pediatric specialists/specialists for services rendered to members <age 21 , regardless of board certification. No additional qualification measures are required.

Emergency room physicians- for services rendered to members <age 21, regardless of whether the physician is in or out of network.

Fraud, waste and abuse

Fraud

An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal or State law.

Waste

Over-utilization of services (not caused by criminally negligent actions) and the misuse of resources.

Abuse

Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

For more information or examples of fraud, waste and abuse, please refer to the Fraud, Waste and Abuse of the provider manual.

Reporting fraud, waste and abuse

Providers can report suspected fraud, waste, or abuse in the following ways:

- Aetna Alert Line: **1-888-891-8910**
- Special Investigation Unit (SIU) Hotline: **1-855-415-1558**
- Email the Special Investigations Unit (SIU): **FL-FraudandAbuse@Aetna.com**
- Fax the SIU: **1-860-975-9719**
- FL Attorney General's Office: **1-866-966-7226**
- Visit our website: **AetnaBetterHealth.com/Florida/fraud-abuse**

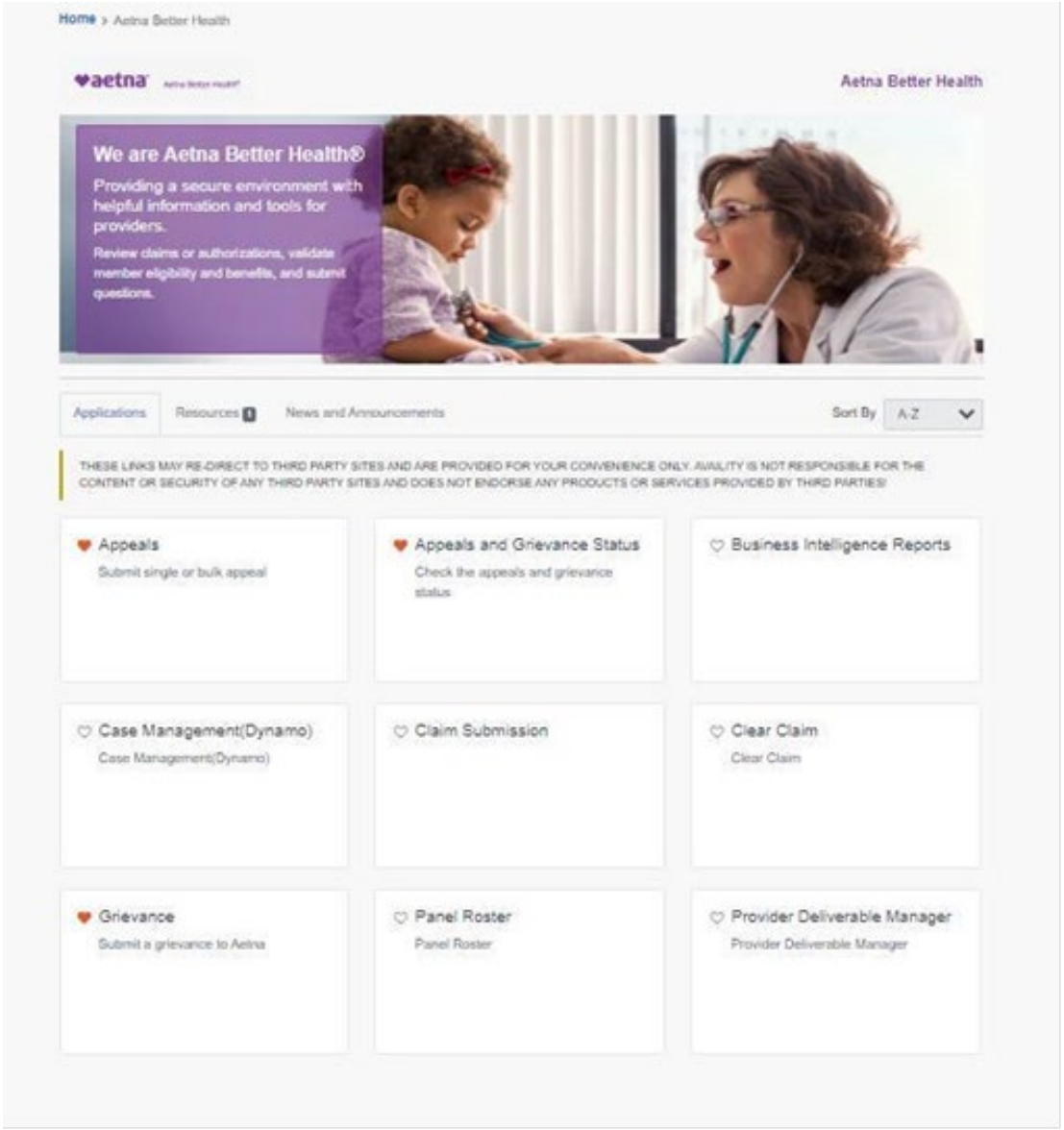
Provider complaint system

The provider complaint system allows providers to dispute any aspect of Aetna Better Health of Florida's policies and procedures, including claims, billing disputes and prior authorizations.

To file a grievance or an appeal:

1. Login to the secure provider portal on Availity.
2. Click on Payer Spaces and select Aetna Better Health of Florida.
3. Go to the Resource tab and select Grievance or Appeals from the menu options.

For more information about filing a grievance or an appeal, please visit our website and select the Complaints, Grievances and Appeals section under the For Providers tab.



Provider complaint types

Type of Complaint	Timing of Appeal	Response Time
Non-Claims Related	Must be submitted within forty-five (45) calendar days from the date the issue occurred.	• Providers will be notified within three (3) business days of receipt verbally or in writing that the complaint has been received and the expected date of resolution. • Providers will receive written notice every 15 days with a status update. • Complaints will be resolved within ninety (90) days of receipt. • Written notice will be sent out to provider within three (3) business days with resolution of complaint
Claims Related	Must be submitted within ninety (90) calendar days of the date of determination (Explanation of Benefits)	• Providers will be notified within three (3) business days of receipt verbally or in writing. • Providers will receive written notice every 15 days with a status update. • Complaints will be resolved within sixty (60) days of receipt of a claim complaint. • Written notice will be sent out to provider within three (3) business days with resolution of complaint

Note - There is no second level consideration for cases denied for untimely filing.

Provider complaint timely filing guidelines

Claim Type	Guideline
Underpayment/ Overpayment	Providers have 365 calendar days after receipt of the notification (EOB/EOP/ Remit) to submit an underpayment claims dispute or submit additional information or documentation. (F.S. 641.3155)
Claim Denial	Providers have ninety (90) calendar days from the time of a claim denial to file a provider claims dispute or submit additional information or documentation. (SMMC Contract) (Section VIII) (D)(5)(d)(1)
Return of requested additional information (itemized bill, ER records, med records, attachments)	A Provider must submit any additional information or documentation as specified, within thirty-five (35) days after receipt of the notification. Additional information is considered received on the date it is electronically transferred or mailed. Aetna Better Health cannot request duplicate documents. (F.S. 641.3155(2)(c)(2)

Quality Improvement (QI) Program

Monitor the coordination and continuity of care across health care network settings and transitions in those settings.

Performance indicators such as HEDIS and state-defined measures.

Results of annual provider and member satisfaction surveys.

Utilization of services provided by hospitals, emergency rooms, physician services, mental health facilities, home health agencies, DME companies and pharmacies.

For a detailed description of our QI Program, please refer to the Quality Improvement section of the provider manual.

HEDIS

HEDIS is a performance measurement requirement administered by NCQA and used by the Centers for Medicare & Medicaid Services (CMS) for monitoring the performance of managed care organizations.

The graphic to the right illustrates how data is collected and ways that you can help ensure all annual standards are met. For a detailed description of the HEDIS program and all NCQA and CMS requirements, please refer to the Measuring Quality Performance section of the provider manual.

To receive HEDIS information specific to your practice or to obtain an electronic version of our Provider HEDIS Resource Guide, please email **FLMedicaidQualityDept@Aetna.com** or contact your Provider Relations representative.

All managed care organizations that are NCQA accredited perform HEDIS reviews at the same time each year.

We rely heavily on providers and their staff to document and maintain accurate medical records.

HEDIS data is collected through two primary methods:
— submitted claims and encounters
— chart collection/review

Providers can help us meet reporting deadlines by allowing us prompt access to medical records upon request.

HEDIS consists of over 80 measures across domains of care that address important health issues and preventive care.

Provider marketing

Providers may

Display Aetna Better Health of Florida-specific materials in their own offices.

Announce a new affiliation with Aetna Better Health of Florida and give their patients a list of managed care plans with which they contract.

Co-sponsor events, such as health fairs and advertise with Aetna Better Health of Florida in indirect ways; such as television, radio, posters, fliers, and print advertisement.

Distribute information about non-Managed Care Plan-specific health care services and the provision of health, welfare and social services by the State of Florida or local communities, as long as any inquiries from prospective members are referred to the member services section of Aetna Better Health of Florida or the Agency's enrollment broker.

Providers may not

Offer marketing/appointment forms, make phone calls or direct, urge or attempt to persuade recipients to enroll in Aetna Better Health of Florida based on financial or any other interests of the provider.

Orally or in writing compare benefits or provider networks among Aetna Better Health of Florida other than to confirm whether they participate in Aetna Better Health of Florida's network.

Furnish lists of their Medicaid patients or any other entity to Aetna Better Health of Florida.

Assist with Managed Care Plan enrollment.

Mail marketing materials on behalf of Aetna Better Health of Florida.

Offer anything of value to induce recipients/members to select them as their provider or enroll in Aetna Better Health of Florida.

Conduct health screening as a marketing activity.

Accept compensation directly or indirectly from the Managed Care Plan for marketing activities.

Distribute marketing materials within an exam room setting.

Cultural competence and mandated reporting

“Cultural competence is the ability of practitioners and systems to respect and respond to diverse member values, beliefs, behaviors and needs (e.g. social, cultural, linguistic) when providing health care services.”

— NCQA

To learn more about our Cultural Competency tools and resources for providers, please visit our website and select the Provider Education section under the For Providers tab.

How you can demonstrate cultural competence

When treating a person with a disability, remember to:

- Talk to the patient, not someone who accompanies them
- Avoid making assumptions
- Ask, “How can I help you?” and respect their response
- Ensure that educational materials are easily accessible
- Allow time for history taking and exam

When treating a person who is deaf or hard of hearing:

- Ask how to best communicate
- Provide written educational material
- Look at the person while speaking
- Avoid shouting
- Minimize background noise
- Provide an interpreter, if necessary, for effective communication
- Patients cannot be charged for interpretation
- Family members should NOT serve as interpreters

When treating a person who is blind or visually impaired, provide written material:

- In an auditory format
- On computer disc
- In Braille
- In large print

When treating a person who is a wheelchair user:

- Provide access to exam areas
- Provide assistance, if necessary, for a full and complete exam, even if it requires more time or assistance
- Respect personal space, including wheelchairs and assistive devices
- Avoid propelling wheelchair unless asked
- Obtain adjustable exam tables for your facility, if possible

Emergency room criteria

Children

As mandated by Florida Administrative Code, emergency room providers are required to examine children for suspected physical abuse and/or neglect when placed in foster homes after normal agency business hours.

Vulnerable adults

Providers must report suspected or known physical abuse (domestic violence), neglect, maltreatment, and/or financial exploitation of a vulnerable adult immediately to one of the following agencies:

The National Domestic Violence Hotline - **1-800-799-SAFE (7233)**
The Florida Department of Health and Human Services- **1-304-558-0684**

Abuse, neglect and exploitation

Aetna Better Health of Florida network providers are considered mandated reporters. As a mandated reporter, you are obligated to report suspected abuse, neglect and/or exploitation to the Florida Abuse Hotline at **1-800-962-2873** or the Plan's Member Services Department at **1-844-528 5815**.

Potential symptoms/Signs of abuse:

- Bruises (old and new)
- Burns or bites
- Pressure ulcers (Bed sores)
- Missing teeth
- Broken Bones / Sprains
- Spotty balding from pulled hair
- Marks from restraints
- Domestic violence

Behaviors of abusers (Caregiver and/or family member):

- Refusal to follow directions
- Speaks for the patient
- Unwelcoming or uncooperative attitude
- Working under the influence
- Aggressive behavior

Types of neglect:

- The intentional withholding of necessities and care
- Not providing necessities and care because of lack of experience, information, or ability

Signs of neglect:

- Malnutrition or dehydration
- Un-kept appearance; dirty or inadequate
- Untreated medical condition
- Unattended for long periods or having physical movements unduly restricted

Examples of neglect:

- Inadequate provision of food, clothing, or shelter
- Failure to attend health and personal care responsibilities, such as washing, dressing, and bodily functions

For more information about your role in reporting suspected cases of abuse, neglect and exploitation, please refer to the Abuse, Neglect and Exploitation section of the provider manual.

Human Trafficking

Human trafficking is a public health issue that impacts individuals, families, and communities. Traffickers disproportionately target at-risk populations including individuals who have experienced or been exposed to other forms of violence.

The Trafficking Victims Protection Act of 2000 (TVPA), as amended (22 U.S.C. § 7102), defines "severe forms of trafficking in persons" as:

- Sex trafficking: the recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purpose of a commercial sex act, in which the commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age; (and)
- Labor trafficking: the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery

Human trafficking may occur in the following situations:

- Prostitution and escort services;
- Pornography, stripping, or exotic dancing;
- Massage parlors;
- Sexual services publicized on the Internet or in newspapers;
- Agricultural or ranch work;
- Factory work or sweatshops;
- Businesses like hotels, nail salons or home-cleaning services;
- Domestic labor (cleaning, childcare, eldercare, etc. within a home);
- Restaurants, bars, or cantinas; or
- Begging, street peddling, or door-to-door sales.

Victims of human trafficking may exhibit any of the following:

- Evidence of being controlled either physically or psychologically;
- Inability to leave home or place of work;
- Inability to speak for oneself or share one's own information;
- Information is provided by someone accompanying the individual;
- Loss of control of one's own identification documents (ID or passport);
- Have few or no personal possessions;
- Owe a large debt that the individual is unable to pay off; or
- Loss of sense of time or space, not knowing where they are or what city or state, they are in.

Help for human trafficking victims

The National Human Trafficking Hotline provides assistance to victims in crisis through safety planning, emotional support, and connections to local resources. For more information on human trafficking visit **acf.hhs.gov/trafficking**.

If you know someone who is a victim of human trafficking or you suspect someone is a victim of human trafficking, you can contact the National Human Trafficking Hotline for assistance in the following ways:

Call: **1-888-373-7888**
Text: **HELP to BEFREE (233733)**
Email: **help@humantraffickinghotline.org**

Attestation requirement

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ATTESTATION OF NEW PROVIDER ORIENTATION - MMA & LTSS

I have received and completed Aetna Better Health of Florida's (ABHFL Self-Guided New Provider Orientation which covers the topics listed below:

- ✓ Language Assistance and Interpreter Services
- ✓ Care for Diverse Populations or Diverse Populations
- ✓ Policies and Procedures
- ✓ Communicating with Members
- ✓ Locating and referring to other ABHFL providers
- ✓ Navigating ABHFL Website
- ✓ MMA and LTSS Kids covered services
- ✓ Claims Payment Policies
- ✓ Referrals and Authorizations
- ✓ Case Management

I have been educated about these essential components of ABHFL's MMA and LTSS product and my responsibilities as a participating provider, including providing this orientation to new practitioners that join our practice.

Date	
Completed by / Title	
Group Name (Print)	
Group NPI	
Tax identification number (TIN)	
Telephone number	
Email address	
Signature	

Important:
ABHFL requires completion of this Attestation, in addition to a signed contract and credentialing, to complete the ABHFL provider enrollment process.

Note:
Failure to complete this Attestation may result in a delay of active status with ABHFL.

Return Signed Attestation via fax or Email
Fax: 844-886-8349
Email: FLMedicaidProviderRelations@aetna.com

Internal Use Only

Received by_____Date_____

Active Status Date_____

FL-20-08-002
Proprietary

Signature required

Questions? We've got answers.

Just call MMA Provider Services at 1-800-441-5501 or LTSS Provider Services at 1-844-645-7371

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